STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445160	A. BUILDING _____ B. WING _____	C 02/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD REHABILITATION CENTER	200 MAYFIELD DRIVE SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the grievance log, observation and interview, the facility failed to resolve a grievance for one (#3) of nine residents reviewed. The findings included: Resident #3 was admitted to the facility on March 1, 2005, with diagnoses including Adult Failure to Thrive, Psychosis, Generalized Anxiety, Senile Dementia, Hypertension, Paralysis Agitans, Gastrointestinal Reflux Disease and Depressive Disorder. Medical record review of the Minimum Data Set dated January 23, 2012, revealed the resident had short and long-term memory problems; required extensive assistance with all activities of daily living (ADL) and was incontinent of bowel and bladder. Review of a grievance investigation dated December 29, 2011, revealed the family of resident #3 voiced a concern regarding a delay in staff performing hygiene after a urinary incontinence episode. Observation and interview in the resident's room	F 166	Incontinent care was provided to Resident #3 by LPN #1 and CNT upon discovery that incontinent care was needed, CNT in-serviced on proper incontinent care 2-8-12. On 2-14-12, Facility staff conducted Interviews of Resident's and / or responsible party related to any concerns or grievances and a grievance form was completed when indicated. Grievances will be followed up on by department manager and results will be reported no later than 3-23-12 to the Administrator. Department managers in-serviced by Administrator on 2-16-12 to complete a grievance form if indicted by a concern voiced during weekly customer service calls. Administrator will utilize a tracking form to ensure follow up on grievances voiced during weekly customer service calls completed by Department managers. Administrator to monitor on an ongoing basis.	2-8-12 2-14-12 3-23-12 2-16-12 2-16-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Debbie L Bowers | TITLE: Administrator | (X6) DATE: 3/8/12

ly deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ner safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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F 166	Continued From page 1 on February 8, 2012, at 3:45 p.m., with the Licensed Practical Nurse (LPN #1)/Treatment Nurse revealed LPN #1 positioned the resident on the left side and unfastened the brief. Observation revealed no bowel movement in the brief. Observation revealed dried bowel movement on both buttocks and the coccyx area with a foul odor from the resident. Interview with LPN #1 confirmed dried bowel movement on the resident's buttocks and coccyx with a foul odor. Interview on February 9, 2012, at 10:20 a.m., in the training room, with the Administrator confirmed the family voiced a grievance on December 29, 2011, related to finding the resident in need of incontinence care.	F 166	Through monthly CQI (Continuous Quality Improvement) meeting, committee will track the number of grievances and the timeframe of resolution. Any report of non-compliance will require follow-up interventions.	3-23-12
F 280 SS=D	C/O #29146, #29276 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after	F 280	Careplan of Resident #3 was reviewed by the careplan team and corrected to reflect current plan of care including interventions to reduce the risk of further injury from the zippered robes.	2-15-12

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F 280	Continued From page 2 each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to update the care plan for one resident (#3) who received an abrasion of nine residents reviewed. The findings included: Resident #3 was admitted to the facility on March 1, 2005, with diagnoses including Adult Failure to Thrive, Psychosis, Generalized Anxiety, Senile Dementia, Hypertension, Paralysis Agitans, Gastrointestinal Reflux Disease and Depressive Disorder. Medical record review of the Minimum Data Set dated January 23, 2012, revealed the resident had short and long-term memory problems and required extensive assistance with all activities of daily living (ADL). Medical record review of a hospice note dated February 6, 2012, revealed, "...Skin assessed per (Licensed Practical Nurse (LPN)/Treatment Nurse #1) et (and)...Risk Manager. Resident has long red area on lower left side of abdomen towards hip area...Risk Manager et (Treatment Nurse) to reinforce (with) facility staff need to be careful and assess all patients for possible injury related to positioning, transferring all patients..." Medical record review of a nurse's note by the	F 280	Beginning on 3-12-12, the treatment nurse will review the skin integrity careplans of all current residents and, then quarterly thereafter. This will be monitored by the Director of Nurses. Completion of initial review: Each discipline will orally review their own careplan during careplan team meeting with discussion as needed. All disciplines are required to attend the Monday through Friday stand up meeting. Each discipline is responsible for care planning any issues/concerns discussed during the meeting that pertains to their discipline. Director of Nursing/Administrator will utilize tracking from for follow up needs related to care planning.	3-30-12 3-12-12 3-13-12

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F 280	Continued From page 3 Risk Manager/LPN #2 dated February 9, 2012, revealed, "Staff reported on 2-4-12 (February 4, 2012) that an abrasion was noted to the left hip and left lower abdomen. No blood was noted at the time. Upon investigation, resident was noted to have been lying on her housecoat, which connects with a zipper...CNT (Certified Nursing Technician) removed the housecoat and repositioned resident to prepare for dinner...states that peri-care was not required at that time and did not notice any markings until the second round when...providing peri-care. Upon assessment, the abrasion shows clean, even lines of rough edges with no broken skin. While assessing the abrasion, (family) was present and displaying a similar housecoat. This writer made the statement that the family may need to consider bring(ing) in coats with snaps instead of zippers as a preventative measure...(Family) replied by stating that people here need to learn how to do their jobs, and we will continue to bring in these housecoats..." Medical record review of the current care plan revealed the care plan had not been updated, after the resident received the abrasion from the zipper on February 4, 2012, to include interventions to reduce the risk of further injury from the zippered robes. Observation on February 8, 2012, at 3:45 p.m., in the resident's room, with Licensed Practical Nurse (LPN #1)/Treatment Nurse revealed the resident lying in bed wearing a gown and a robe with a zipper. Observation revealed a red area on the left lower abdomen extending upward and outward toward the left hip with a length estimated by the Treatment Nurse of "20 cm	F 280	Monday through Friday stand-up meeting committee members will be in-serviced on this procedure Results of the Care plan interventions and Follow-up will be reported during the monthly Continuous Quality Improvement meeting. The Director of Nurses and Care plan Coordinator will be responsible to monitor this process and insure compliance.	3-13-12 3-23-12 3-23-12

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F 280	Continued From page 4 (centimeters)". Observation revealed the width of the red area matched the width of the zipper on the robe and revealed multiple, tiny rough areas along the abrasion. Telephone interview and medical record review on February 14, 2012, at 10:35 a.m., with the Director of Nursing (DON) revealed the facility investigation of the abrasion led staff to determine the abrasion was caused by the resident lying on the zipper. Continued interview with the DON confirmed the DON had reviewed the current care plan and confirmed the care plan had not been updated with interventions to reduce the risk of further injury from zippered robes. C/O #29276	F 280		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation and interview, the facility failed to ensure one resident (#3) received appropriate incontinence care after a bowel movement of nine residents reviewed. The findings included: Resident #3 was admitted to the facility on March	F 312	Incontinent care was provided to Resident #3 by LPN #1 and CNT upon discovery that incontinent care was needed. CNT in serviced on proper incontinent care per facility policy and procedure on 2-8-12	2-8-12

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F 312	Continued From page 5 1, 2005, with diagnoses including Adult Failure to Thrive, Psychosis, Generalized Anxiety, Senile Dementia, Hypertension, Paralysis Agitans, Gastrointestinal Reflux Disease and Depressive Disorder. Medical record review of the Minimum Data Set dated January 23, 2012, revealed the resident had short and long-term memory problems; required extensive assistance with all activities of daily living (ADL) and was incontinent of bowel and bladder. Review of the facility's policy for incontinence care revealed, "...PURPOSE...to ensure adequate skin care...To control odor, prevent skin damage...To provide care in a manner that preserves resident dignity...Remove the fecal material from the resident's buttocks area using toilet tissue...Wash, rinse and dry the buttocks area...Go to the other side of the bed; lower the bed rail; expose the resident's buttocks area; wash, rinse, and dry the exposed area..." Observation and interview in the resident's room on February 8, 2012, at 3:45 p.m., with the Licensed Practical Nurse (LPN #1)/Treatment Nurse revealed LPN #1 positioned the resident on the left side and unfastened the brief. Observation revealed no bowel movement in the brief. Observation revealed dried bowel movement on both buttocks and the coccyx with a foul odor from the resident. Interview with LPN #1 confirmed dried bowel movement on the resident's buttocks and coccyx with a foul odor. C/O #29146, #29276	F 312	On 2-14-12, Facility staff conducted Interviews of Resident's and / or responsible party related to any concerns or grievances and a grievance form was completed when indicated. Grievances will be followed up on by department manager and results will be reported no later than 3-23-12 to the Administrator. Nursing staff in-serviced on incontinence care per facility policy and procedure started on 2-10-12 with completion by 3-23-12. Nurse Administration (Restorative Nurse, Risk Manager, Treatment Nurse, Staff Development Nurse (2) Unit Manager, and Medical Records Nurse) will provide incontinent care competencies on 5 CNT's until all current CNT's have successfully completed an incontinent care competency. Incontinent care competencies will be conducted during new employee orientation and during CNTs annual review: Begin; 3-23-12 DON will monitor compliance of incontinent care competencies and report results in monthly Continued Quality Improvement meeting.	3-23-12 3-23-12 3-23-12
F 323	483.25(h) FREE OF ACCIDENT	F 323		

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F 323	483.25(h) FREE OF ACCIDENT	F 323		

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F 323 SS=D	Continued From page 6 HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of a facility investigation, observation and interview, the facility failed to supervise one resident (#3) to prevent an abrasion of nine residents reviewed. The findings included: Resident #3 was admitted to the facility on March 1, 2005, with diagnoses including Adult Failure to Thrive, Psychosis, Generalized Anxiety, Senile Dementia, Hypertension, Paralysis Agitans, Gastrointestinal Reflux Disease and Depressive Disorder. Medical record review of the Minimum Data Set dated January 23, 2012, revealed the resident had short and long-term memory problems and required extensive assistance with all activities of daily living (ADL). Medical record review of a hospice note dated February 6, 2012, revealed, "...Skin assessed per (Licensed Practical Nurse (LPN)/Treatment Nurse #1) et (and)...Risk Manager. Resident has long red area on lower left side of abdomen	F 323	CNT in serviced related to supervision of residents to prevent injury on 2-17-12. All nursing staff to be in serviced related to supervision of residents to prevent injury, completed by;3-23-12. Unit manager or designee will randomly monitor 10 residents per week to assure appropriate supervision of Resident's to prevent injury. Director of Nursing or designee will monitor compliance weekly times four then monthly thereafter. Compliance will be reviewed monthly in Continued Quality Improvement meeting. Begin;	2-17-12 3-23-12 3-12-12

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F 323	Continued From page 7 towards hip area...Risk Manager et (Treatment Nurse) to reinforce (with) facility staff need to be careful and assess all patients for possible injury related to positioning, transferring all patients..." Medical record review of a nurse's note by the Risk Manager/LPN #2 dated February 9, 2012, revealed, "Staff reported on 2-4-12 that an abrasion was noted to the left hip and left lower abdomen. No blood was noted at the time. Upon investigation, resident was noted to have been lying on her housecoat, which connects with a zipper, the CNT (Certified Nursing Technician) removed the housecoat and repositioned resident to prepare for dinner...states that peri-care was not required at that time and did not notice any markings until the second round when...was providing peri-care. Upon assessment, the abrasion shows clean, even lines of rough edges with no broken skin. While assessing the abrasion, (family) was present and displaying a similar housecoat. This writer made the statement that the family may need to consider bring(ing) in coats with snaps instead of zippers as a preventative measure...(Family) replied by stating that people here need to learn how to do their jobs, and we will continue to bring in these housecoats..." Review of a written statement by the Risk Manager dated February 9, 1012, of an interview with the Certified Nursing Assistant (CNA #1) who first reported the abrasion to Licensed Practical Nurse (LPN) #2 revealed, "...noted (resident) already in bed during walking rounds with a personal night gown and...housecoat/robe. When (CNA) #1 performed the first round for turning and repositioning and brief check...noted	F 323		

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F 323	Continued From page 8	F 323		

resident lying on...left side with the coat under the resident. After noting the resident was dry...removed the coat and provided turning and repositioning to be ready for dinner. After dinner (CNA #1) performed a second round, sometime around the 6 o'clock (p.m.) hour, and noted that the resident required incontinence care. While providing care...noted abrasion that was still red to the left hip and abdomen...asked the other (CNA)...to verify that it was a new spot, which was confirmed...then notified charge nurse...denies any other difficulties with turning and repositioning or peri-care for remainder of the shift..."

Review of a written statement (undated) by the Licensed Practical Nurse (LPN) #2/Unit Manager revealed, "Was called to resident's room, resident was lying in bed...(CNA) was about to change brief when...noticed abrasion on left hip and asked me to check...(Resident) was lying flat on...back dressed in gown. Two (CNAs) assisted with turning (resident) on...right side, while I checked...abrasion. Area was cleaned, no bleeding or open areas noted. Bed checked for anything in bed, side rails checked for rough areas. Wheelchair checked for rough areas none found."

Observation and interview on February 8, 2012, at 3:45 p.m., in the resident's room, with LPN #1/Treatment Nurse revealed the resident lying in bed wearing a gown and a robe with a zipper. Observation revealed a red area on the left lower abdomen which extended upward and outward toward the left hip with a length estimated by the Treatment Nurse of "20 cm (centimeters)". Observation revealed the width of the red area

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F 323	Continued From page 9	F 323		

matched the width of the zipper on the robe and revealed multiple, tiny scabbed areas along the abrasion. Interview with the Treatment Nurse at the time of the observation revealed the facility's investigation determined the abrasion may have been caused by the resident lying on the zipper of the robe.

Interview on February 9, 2012, at 10:20 a.m., in the training room, with the Administrator confirmed the resident received an injury to the left abdomen which, after initiating an investigation, the facility determined was caused by the resident lying on the zipper of the robe.

Interview on February 9, 2012, at 10:55 a.m., in the conference room, with LPN #2/Unit Manager revealed two Certified Nursing Assistants informed LPN #2 on February 4, 2012, on the 3:00 p.m., to 11:00 p.m., shift of an injury to the resident's left lower abdomen. Continued interview revealed the resident required extensive assistance with bed mobility and a lift for transfers from the bed. Continued interview with LPN #2 confirmed the area on the left lower abdomen had the appearance of a "little railroad track." Continued interview confirmed LPN #2 checked the resident's wheelchair, bed and sling for rough edges which might have caused the injury and none were found. Continued interview revealed the resident's family had first raised the possibility the abrasion was caused by the zipper in the robe, and the results of the facility's investigation of the injury determined the injury was caused by the resident lying on the zipper.

Telephone interview on February 14, 2012, at 2:10 p.m., with CNA #1 confirmed when CNA #1

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F 323	Continued From page 10 first observed the resident on February 4, 2012, between 4:30 p.m., and 5:00 p.m., the resident was lying on the left side. Continued interview confirmed CNA #1 removed the robe which required "a little bit of strength" because the resident required extensive assistance with repositioning. The CNA denied observing the resident's skin at the time the robe was removed and denied the resident had any expression of pain or discomfort when the robe was removed. Continued interview confirmed when CNA #1 observed the resident at 6:00 p.m., the CNA observed the abrasion on the abdomen and left hip area and notified the charge nurse. C/O #29276	F 323		